SERFF Tracking Number:	*FHLA-127619145*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*49746*
Company Tracking Number:	*H4ARPOL*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002 Dread Disease*
Product Name:	*Individual Specified Disease (Heart/Stroke) Policy*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Family Heritage Life Insurance Company of America

Product Name: Individual Specified Disease (Heart/Stroke) Policy	SERFF Tr Num: FHLA-127619145	State: Arkansas
TOI: H07I Individual Health - Specified Disease - - Limited Benefit	SERFF Status: Closed-Approved-Closed	State Tr Num: 49746
Sub-TOI: H07I.002 Dread Disease	Co Tr Num: H4ARPOL	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Kevin Wicktora, Kim Scott	Disposition Date: 09/27/2011
	Date Submitted: 09/09/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 09/27/2011
	State Status Changed: 09/27/2011
Deemer Date:	Created By: Kim Scott
Submitted By: Kim Scott	Corresponding Filing Tracking Number:

Filing Description:

Please see the cover letter.

Company and Contact

Filing Contact Information

Kim Scott, Compliance Analyst	kim.scott@familyheritagelife.com
6001 E. Royalton Rd.	440-922-5156 [Phone]

SERFF Tracking Number:	*FHLA-127619145*	*State:*	*Arkansas*
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Suite 200
Cleveland, OH 44147

Filing Company Information

Family Heritage Life Insurance Company of America	CoCode: 77968	State of Domicile: Ohio
6001 East Royalton Road	Group Code:	Company Type: Life & Health
Suite 200	Group Name:	State ID Number:
Cleveland, OH 44147	FEIN Number: 34-1626521	
(440) 922-5200 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$300.00
Retaliatory?	No
Fee Explanation:	6 forms at $50 per form = $300
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Heritage Life Insurance Company of America	$300.00	09/09/2011	51410088

SERFF Tracking Number:	*FHLA-127619145*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/27/2011	09/27/2011

SERFF Tracking Number:	*FHLA-127619145*	*State:*	*Arkansas*
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Disposition

Disposition Date: 09/27/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FHLA-127619145*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Sample Policy Schedule	Approved-Closed	Yes
Form	Heart Disease, Heart Attack, and Stroke Policy	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Change Form	Approved-Closed	Yes
Form	Outline of Coverage Form	Approved-Closed	Yes
Form	Claim Form	Approved-Closed	Yes
Form	Underwriting Information Release Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: H4POLRAR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/27/2011	H4POLRAR	Policy/Contract/Fraternal Certificate	Heart Disease, Heart Attack, and Stroke Policy	Initial			H4POLRAR.pdf
Approved-Closed 09/27/2011	H4APP-AR	Application/Enrollment Form	Application	Initial			H4APP-AR.pdf
Approved-Closed 09/27/2011	H4CHG-AR	Application/Enrollment Form	Change Form	Initial			H4CHG-AR.pdf
Approved-Closed 09/27/2011	H4OOCRAR	Outline of Coverage	Outline of Coverage Form	Initial			H4OOCRAR.pdf
Approved-Closed 09/27/2011	H4CLM-AR	Other	Claim Form	Initial			H4CLM-AR.pdf
Approved-Closed 09/27/2011	H4UIR-AR	Other	Underwriting Information Release Form	Initial			H4UIR-AR.pdf

FAMILY HERITAGE
Life Insurance Company Of America
Executive Office: P.O. Box 470608
Cleveland, Ohio 44147
(440) 922-5222

Heart Disease, Heart Attack, and Stroke Policy

THIS IS A LIMITED POLICY- PLEASE READ IT CAREFULLY

POLICY INDEX

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.
If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

THIS POLICY HAS A 30-DAY WAITING PERIOD. NO BENEFITS ARE PAYABLE FOR HEART DISEASE, HEART ATTACK, OR STROKE DIAGNOSED WITHIN 30 DAYS OF THE POLICY EFFECTIVE DATE. If You are diagnosed with Heart Disease, Heart Attack, or Stroke before the end of the Waiting Period, We will void the policy from the beginning and You will receive a full refund of Premium.

This policy is a legal contract between the Policyowner and Family Heritage Life Insurance Company of America. We agree to insure You against loss from Heart Disease, Heart Attack, and Stroke (as defined) in return for Your Premium payments.

TEN DAY RIGHT TO EXAMINE THE POLICY: If for any reason, You are not satisfied with this policy, it can be returned to an authorized agent of the Company or to our Executive Office within 10 days after You receive it for a complete refund of Premium and cancellation of the policy.

IT IS IMPORTANT that You read Your entire policy, including the application and write to Us within 10 days if any information shown in the application is incorrect or incomplete.

GUARANTEED RENEWABILITY: This policy is continuously renewed during the Policyowner's lifetime by the payment of Premiums when due. We reserve the right to change Premium rates upon 60 days prior written notice. Such changes may only be made for all policies of this kind issued in the same state. You cannot be singled out for a rate change.

This policy is signed on behalf of FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA by its Secretary and President.

Edward J. Rocheck — Secretary

Howard L Levine — President

SECTION 1: DEFINITIONS

When the terms below are used in this policy, the following definitions apply:

CHILD, CHILDREN: Means the Policyowner's natural children, step-children, legally adopted children, children placed with You for adoption, children petitioned for adoption, or children for whom the Policyowner has permanent legal custody. Each Child must be insurable, unmarried, dependent on the Policyowner or the Policyowner's Spouse for a majority of the Child's support, and younger than age 25. A Child will be considered dependent if he or she qualifies as a legal dependent of You or Your Spouse for tax exemption purposes under the U.S. Internal Revenue Service (IRS) Tax Code. The insurance on any Child will terminate at 12:00 noon (Eastern Standard Time) on the Child's 25th birthday, the Child's marriage, or when the Child no longer qualifies as a legal dependent for tax exemption purposes, whichever occurs first. Terminations will not affect previously incurred claims (for continuation of coverage, see SECTION 5: GENERAL PROVISIONS – CONVERSION).

Adopted Children: If this is a Family or Single Parent Policy, the Policyowner's adopted Children are covered from the moment of adoption and Children placed with You for adoption are covered from the moment of petition or placement. No notice or additional Premium is required.

If this is an Individual or Married Couple Policy, coverage shall begin on the date of the filing of a petition for adoption if coverage is applied for within 60 days after the filing of the petition for adoption. Newborn Children are covered from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the Child's birth and You pay the additional premium to continue coverage beyond 60 days.

Handicapped Children: If this is a Family or Single Parent Policy, Children also includes dependent Children, regardless of age, who are mentally or physically handicapped and became or become handicapped prior to age 25, and cannot support themselves because of their handicap. Proof of continued handicap and dependency must be provided upon Our request, but not more often than annually, after two years following the Child's 25th birthday.

Newborn Children: If this is a Family or Single Parent Policy, the Policyowner's newborn Children are covered from the moment of live birth and no notice or additional Premium is required.

If this is an Individual or Married Couple Policy, the Policyowner's newborn Children are covered from the moment of live birth for the next 31 days. We must be notified within 31 days after the date of birth and receive payment of the required Premium in order to have coverage continue beyond the 31 day period.

CLAIMS INCURRED: A claim for benefits under Your policy or rider is considered incurred on the date the event or service occurs for which We pay benefits.

DOCTOR, PHYSICIAN: Means a person, other than You or a member of Your family, who is licensed by the state to practice a healing art and performs services which are allowed by his or her license.

HEART ATTACK: Means a myocardial infarction. A myocardial infarction occurs when the blood supply to the heart is severely reduced resulting in damage to the heart muscle. Heart Attack does not include angina or any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a myocardial infarction is not a Heart Attack.

HEART DISEASE: Means a pathological condition of the heart, coronary arteries, or the pericardium. Heart Disease does not mean abnormal blood pressure, angina, or any disease or disorder of blood vessels other than the coronary arteries.

HEART TRANSPLANT: Means the surgical removal by a surgeon of the entire heart (including all atria, ventricles, and valves) and replacement with a human heart. A Heart Transplant does not include the replacement of a human heart with a non-human, mechanical, or artificial heart.

HOSPITAL: Means a medical facility, located in the United States, which is legally licensed and operated as an acute-care hospital, provides overnight care of injured and sick people, is supervised by a Doctor, provides 24-hour-a-day nursing services by or under the supervision of a registered professional nurse, and provides on-site or prearranged use of X-ray equipment, laboratory facilities, and surgical units, and maintains permanent medical history records.

A Hospital is not a bed, unit, or facility that functions as a nursing home, hospice, skilled nursing facility, extended care facility, convalescent home, a place for rehabilitation, rest home or a home for the aged, a place for the treatment of substance abuse, a sanatorium, or a mental institution.

HOSPITALIZATION, HOSPITALIZED: Means the period of time from Your admission as an inpatient to a Hospital, to Your discharge from that Hospital. If you are admitted as an inpatient to a Hospital within 30 days following such a discharge, then the period of time from this subsequent admission to a later discharge will be treated as a continuation of the Hospitalization and not a separate Hospitalization. Hospitalization does not include the period that You are being treated as an outpatient or in an Observation Room.

POLICY ANNIVERSARY DATE: Means the yearly recurrence of the Policy Effective Date shown on the Policy Schedule.

POLICYOWNER: Means the person named in the Policy Schedule as the Policyowner.

PREMIUM: Means the amount of money You pay Us in return for the insurance provided by this policy and any rider(s).

RETURN OF PREMIUM MATURITY DATE: Means the later of:

- the 20th Policy Anniversary Date; or
- the date when We have received 20 full years of Premium and We have provided 20 full years of coverage.

SPOUSE: Means the insurable person named as Spouse on the Policy Schedule and married to the Policyowner as evidenced by a government issued license.

STROKE: Means a cerebrovascular accident which results in paralysis or other neurological deficits as documented by clinical findings and diagnostic procedures. A cerebrovascular accident means a sudden, unexpected interference in the brain function resulting from an insufficient supply of blood to part of the brain. Stroke does not mean a head injury, transient ischemic attack, chronic cerebrovascular insufficiency, aneurysm, or heat stroke.

U.S. GOVERNMENT HOSPITAL: Means a hospital which is operated by or for the United States Government and does not charge prevailing market rates for its services.

WE, US, OUR, THE COMPANY: Means Family Heritage Life Insurance Company of America.

YOU, YOUR: If this is an Individual Policy, You means only the Policyowner. If this is a Family Policy, You means the Policyowner and the Policyowner's Spouse and Children. If this is a Single Parent Policy, You means the Policyowner and the Policyowner's Children. If this is a Married Couple Policy, You means the Policyowner and the Policyowner's Spouse.

The Policyowner may be able to add coverage for a Spouse and/or Child(ren) to this policy after the Policy Effective Date. To do so, We must receive an application for the person along with evidence satisfactory to Us that the person is eligible and insurable. If the application is approved, We will notify the Policyowner of the date the added person's coverage becomes effective. A Spouse and/or Child(ren) added to this policy after the Policy Effective Date will not be covered until 30 days after the application for their coverage has been approved by Us.

SECTION 2: ELIGIBILITY FOR BENEFITS

DIAGNOSIS: To be eligible for benefits under this policy (except the Healthy Heart Benefit), Your Heart Disease, Heart Attack, or Stroke must be positively diagnosed in one of the following ways:

Heart Disease must be positively diagnosed by a Physician through physical examination and diagnostic tests.

Heart Attack must be positively diagnosed by a Physician through clinical findings with corroboration from electrocardiogram (EKG/ECG), blood enzyme, or heart catheterization evidence.

Stroke must be positively diagnosed by a Physician through clinical findings with corroboration from an electro-encephalogram (EEG), imaging tests, or blood flow tests.

For the purposes of this policy, the date of diagnosis is the day that the above tests and examinations are completed, and not any later date that the diagnosis is communicated to a covered person.

ELIGIBILITY: You will be eligible for benefits under this policy if:

- You have never been diagnosed with Heart Disease, Heart Attack, or a Stroke prior to 30 days after You became covered under this policy, unless We have specifically waived or amended this requirement;
- Your Heart Attack or Stroke first occurs while You are covered by this policy or Your Heart Disease is first diagnosed while You are covered by this policy;
- You have Claims Incurred due to Your Heart Disease, Heart Attack, or Stroke while this policy is in force and You are covered by this policy; and
- the loss is not excluded by name or specific description in this policy.

If Heart Disease, Heart Attack, or Stroke is first diagnosed while You are Hospitalized, You will be eligible for benefits retroactively, beginning with the date You were admitted to the Hospital, but not more than 30 days prior to the date of diagnosis. You will not be eligible for benefits for Hospitalizations which began prior to the date You became covered under this policy. If Your Heart Disease, Heart Attack, or Stroke is first diagnosed after You die, You will be eligible for benefits if Your policy was in force at the time of Your death.

SECTION 3: BENEFITS

OUR PROMISE TO PAY: Subject to the terms, conditions, limitations, and exclusions of this policy, We will pay the benefits described below:

FIRST OCCURRENCE BENEFIT: We will pay **[$1,000/$2,000/$3,000]** when You are diagnosed for the first time, while covered under this policy, as having had a Heart Attack or Stroke. **We will not pay this benefit for a diagnosis of Heart Disease.** We will pay this benefit only once per covered person, regardless of the number of times You are diagnosed with a Heart Attack or Stroke. We will pay this benefit even when a Heart Attack or Stroke is diagnosed after Your death.

HOSPITALIZATION BENEFIT: We will pay **[$150/$300/$450]** for each day You are Hospitalized for the treatment of Heart Disease, Heart Attack, or Stroke. This benefit will be calculated based on the number of days the Hospital charges You for room and board. If You receive treatment in a U.S. Government Hospital, this benefit will be calculated based on the number of days You are Hospitalized.

AMBULANCE BENEFIT: We will pay charges up to **[$200/$400/$600]** per one-way trip, if a licensed surface or air ambulance service transports You to or from a Hospital where You are Hospitalized for the treatment of Heart Disease, Heart Attack, or Stroke. This benefit is limited to two one-way trips per Hospitalization.

HEART TRANSPLANT BENEFIT: We will pay **[$50,000/$100,000/$150,000]** if, because of Heart Disease or Heart Attack, Your heart can no longer adequately function and You are at risk of dying and as a result You receive a Heart Transplant. We will pay this benefit no more than once for any covered person.

SURGERY AND ANESTHESIA BENEFIT: We will pay **[$200/$400/$600]** for Your surgery and anesthesia. The surgery must be performed by a Doctor to treat or diagnose Your Heart Disease, Heart Attack, or Stroke.

We will also pay **[$200/$400/$600]** for each day of Hospitalization necessary to recover from Your surgery beginning with the day of Your surgery. This payment will be made for each such day a Hospital charges You for room and board, or if Your surgery is performed in a Hospital that does not charge You for room and board, we will pay for each such day of Hospitalization.

This benefit is payable in addition to the Hospitalization Benefit, but only once per Hospitalization. This benefit is limited to **[$5,000/$10,000/$15,000]** per surgery.

PHYSICAL THERAPY BENEFIT: We will pay **[$30/$60/$90]** for each day that You receive the services of a registered physiotherapist. We will pay this benefit for the same number of days for which You receive benefits under the Hospitalization Benefit, up to a maximum of 30 days per Hospitalization.

HEALTHY HEART BENEFIT: We will pay **[$30/$60/$90]** for one Cholesterol Screening for each covered person that is performed within the first 12 months following the Policy Effective Date.

We will also pay up to a maximum of **[$50/$100/$150]** per calendar year for each covered person who has one or more of the following tests performed:

- **[$50/$100/$150**] for a cardiac Magnetic Resonance Imaging (MRI); and
- **[$30/$60/$90]** for an Electrocardiogram (EKG or ECG), Cardiac Stress Test, Echocardiogram (Echo), Cardiac X-ray, or Computed Tomography.

The above tests must be administered by a medical professional. No diagnosis of Heart Disease, Heart Attack, or Stroke is required for this benefit to be payable. This benefit is not subject to the 30-day Waiting Period.

TRANSPORTATION BENEFIT: We will pay this benefit if You must travel to a Hospital that is more than 80 miles one-way from Your residence for:
- up to three (3) appointments with a Physician concerning Your diagnosed Heart Disease, Heart Attack, or Stroke that occur before treatment begins; or
- anytime You receive covered treatment for Your diagnosed Heart Disease, Heart Attack, or Stroke that is prescribed by Your local Physician that is not available where You live.

For Your coach class airplane, train, or bus fare on a regularly scheduled commercial route to the Hospital, We will pay charges up to **[$1,000/$2,000/$3,000]** per round trip. For Your travel by automobile, We will pay **[20 cents/40 cents/60 cents]** for each mile You travel. To determine the mileage, We will measure the distance from where You live to the Hospital using the most direct route.

FAMILY MEMBER TRANSPORTATION BENEFIT: We will pay this benefit if:
- You are eligible for the Transportation Benefit;
- a Family Member also travels to the Hospital; and
- the Hospital is more than 80 miles one-way from where the Family Member lives.

For Your Family Member's coach class airplane, train, or bus fare on a regularly scheduled commercial route to the Hospital, We will pay charges up to **[$1,000/$2,000/$3,000]** per round trip. For travel by automobile, We will pay **[20 cents/40 cents/60 cents]** for each mile the Family Member travels. To determine the mileage, We will measure the distance from where the Family Member lives to the Hospital using the most direct route. The mileage benefit is not payable if the Family Member travels in the same automobile with You.

This benefit is limited to one Family Member making one round trip for each time We pay the Transportation Benefit. "Family Member" means Your Spouse, parent, grandparent, grandchild, brother, sister, or Child.

SECOND PARENT TRANSPORTATION BENEFIT: We will pay this benefit if the Family Member Transportation Benefit is paid for a parent and a second parent also travels to the Hospital under all of the following conditions:
- this is a Family Policy;
- the Transportation Benefit is payable for a covered Child; and
- the Hospital is more than 80 miles one-way from where the second parent lives.

For the second parent's coach class airplane, train, or bus fare on a regularly scheduled commercial route to the Hospital, We will pay charges up to **[$1,000/$2,000/$3,000]** per round trip. For travel by automobile, We will pay **[20 cents/40 cents/60 cents]** for each mile the second parent travels. To determine the mileage, We will measure the distance from where the second parent lives to the Hospital using the most direct route. The mileage benefit is not payable if the second parent travels in the same automobile with You. This benefit is limited to a second parent making one round trip for each time We pay the Transportation Benefit.

FAMILY MEMBER LODGING BENEFIT: We will pay charges up to **[$50/$100/$150]** for a Family Member's lodging in a hotel or motel under the following conditions:
- You are Hospitalized for treatment of Your Heart Disease, Heart Attack, or Stroke; and
- Your Family Member also travels to a Hospital that is more than 80 miles one-way from where You and Your Family Member live.

"Family Member" means Your Spouse, parent, grandparent, grandchild, brother, sister, or Child. This benefit is limited to payment for one hotel or motel room for each day of Your Hospitalization, up to a maximum of 60 days for each period of Hospitalization.

RETURN OF PREMIUM BENEFIT: You will be eligible for the Return of Premium Benefit if You keep Your policy in force until the Return of Premium Maturity Date. You are not required to surrender Your policy on the Return of Premium Maturity Date to receive this benefit.

The benefit amount is equal to the Premiums paid while this policy was in force minus any Claims Incurred prior to the Return of Premium Maturity Date. Premiums paid for any rider will be included in the benefit amount only if that rider is in force on the Return of Premium Maturity Date.

If this is an Individual Policy or Single Parent Policy and the Policyowner dies while this policy is in force and prior to the Return of Premium Maturity Date, We will pay a benefit amount equal to the Premiums paid while this policy was in force, minus any Claims Incurred while this policy was in force. We will pay this benefit upon Our receipt of proof of the Policyowner's death.

If this is a Family Policy or Married Couple Policy and the Policyowner and Spouse both die while this policy is in force and prior to the Return of Premium Maturity Date, We will pay a benefit amount equal to the Premiums paid while this policy was in force, minus any Claims Incurred, while this policy was in force. We will pay this benefit upon Our receipt of proof of the Policyowner and Spouse's death.

SECTION 4: LIMITATIONS AND EXCLUSIONS

HEART DISEASE, HEART ATTACK, AND STROKE POLICY ONLY: Except for the Healthy Heart and Return of Premium Benefits, this policy provides benefits only for loss due to Heart Disease, Heart Attack, or Stroke which occurs more than 30 days after the Policy Effective Date. This includes conditions or diseases caused or aggravated by or resulting from Heart Disease, Heart Attack, or Stroke or the treatment of Heart Disease, Heart Attack, or Stroke.

Benefits paid for any one person will not exceed the maximum benefits shown in the policy regardless of the number or types of Heart Disease, Heart Attack, or Stroke.

A diagnosis of cardiac arrest is not, by itself, a positive diagnosis of Heart Disease, Heart Attack, or Stroke.

SECTION 5: GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the application, Policy Schedule, and any attached riders, amendments, or endorsements, constitutes the entire contract of insurance. No change to this policy is valid until approved and endorsed by one of Our executive officers and attached to this policy. No agent has authority to change this policy or to waive any of its provisions.

CHANGE OF BENEFICIARY: The right to Change of Beneficiary is reserved to the Policyowner and the Policyowner can ask Us to change the Beneficiary at any time. The consent of the Beneficiary or Beneficiaries will not be required in order to change the Beneficiary or to make any other changes in this policy. The Policyowner's request must be in writing and the change must be approved by Us. If approved, it will go into effect the day the Policyowner signs the request. The change will not have any bearing on payments made before We received the request.

TERM: This policy becomes effective at 12:00 noon (Eastern Standard Time) on the Policy Effective Date shown on Your Policy Schedule. Each renewal term ends at 12:00 noon (Eastern Standard Time) on the date to which Your Premium is paid. Renewal dates are determined by mode of payment. Your initial mode of payment is shown on Your Policy Schedule.

PREMIUMS: The first Premium is due on the Policy Effective Date. Each Premium after the first is due on the last day of the term for which the most recent Premium was paid and must be paid to Us at Our Executive Office.

This policy will not be in force until Your application is approved and the first Premium is accepted by Us. If We accept subsequent Premium, this policy will continue in force until the end of the term for which the Premium is due. The amount of the first Premium for the initial mode of payment is shown in the Policy Schedule. The amount of each Premium after the first is based on Your then current mode of payment.

UNEARNED PREMIUM: If the Policyowner dies and the policy is not continued by the covered Spouse as described under the Continuation provision, any proceeds payable to the Policyowner's estate will include premiums paid for any period beyond the end of the policy month in which the death occurred. Unearned premiums shall be paid in a lump sum on a date no later than 30 days after the proof of the Policyowner's death has been furnished to Us.

GRACE PERIOD: If You do not pay a Premium when it is due, You can pay it during the next 31 days. This period is known as the Grace Period. During this Grace Period, the policy will stay in force, but will terminate if You do not pay the Premium by the end of the 31 days.

CANCELLATION OF INSURANCE: The Policyowner may cancel this policy at any time. The Policyowner's request must be in writing and sent to Us at Our Executive Office. Cancellation will become effective on the day We receive the request, or on a later date specified in Your request. In the event of cancellation, we will promptly return the unearned portion of any Premium paid. This will be calculated using the pro-rata portion of any Premium paid. If any claim originated prior to the effective date of cancellation, We will pay the appropriate benefits due. We cannot cancel this policy for any reason other than nonpayment of Premium.

REINSTATEMENT: If this policy terminates because You do not pay the Premium by the end of the Grace Period, You may be able to put Your insurance back in force.

If We or Our authorized agent accept Your Premium and We do not require a reinstatement application, this policy will be reinstated as of 12:00 noon (Eastern Standard Time) on the date We receive the Premium. If We or Our authorized agent require a reinstatement application at the time We accept the Premium, We will issue You a conditional receipt for the Premium. Upon Our receipt and approval of the reinstatement application, this policy will be reinstated as of 12:00 noon (Eastern Standard Time) on the date the reinstatement application is approved. If We do not mail written notice of disapproval of the reinstatement application within 45 days after the date of the conditional receipt, then this policy will automatically be reinstated as of 12:00 noon (Eastern Standard Time) on the 45th day.

The reinstated policy will cover only loss incurred more than 10 days after the reinstatement date. Any Premium accepted in connection with a reinstatement may be applied to a period for which Premium was due, but not to a period of more than 60 days prior to the date of reinstatement.

If an Intensive Care Unit Rider is included in this policy, the rider will not provide benefits for Hospitalization, whether or not in an Intensive Care Unit, which begin prior to the reinstatement date.

We reserve the right to make changes to this policy before We reinstate it. Any changes will be noted on or attached to the reinstated policy. In every other way, Your rights and Our rights will be the same.

CONTINUATION: In the event of the Policyowner's death, the Spouse, if covered under the policy, shall become the Policyowner. We will need proof of the Policyowner's death (a death certificate) in order to make this change.

CONVERSION: If the Policyowner's Spouse is covered under this policy and would lose coverage because of divorce or annulment, or a covered dependent Child would lose coverage because of marriage, attainment of the limiting age, or the Policyowner's death, then Your Spouse and/or Child may convert to a separate policy. A written request for conversion, along with the appropriate Premium, must be sent to Our Executive Office within 60 days after the date coverage would otherwise end. We will issue, without evidence of insurability, an equal or similar policy. The converted policy will be limited by any exclusions which applied under this policy. Additionally, any benefit amounts paid for a person under this policy will be applied to benefit limits under that person's converted policy.

CHANGE IN COVERAGE: If You are diagnosed with Heart Disease, Heart Attack, or Stroke within 30 days following an increase in Your coverage, We will charge Premiums and pay benefits at Your prior level of coverage.

MISSTATEMENTS OF AGE: If any age or date of birth is misstated in the application, benefit amounts will be determined based on the appropriate age at the time coverage was purchased. If, based on the correct ages, We would not have issued this policy or covered certain members of Your family under this policy, then Our only responsibility will be to refund the excess Premium paid.

TIME LIMIT ON CERTAIN DEFENSES: We rely on the statements made in the application when issuing this insurance. After Your insurance has been in force for two years, We cannot deny a claim or void the policy due to a misstatement, except a fraudulent misstatement, made by the applicant in the application.

No claim for loss incurred after two years from the date You become covered under this policy will be reduced or denied on the ground that a disease or physical condition, not excluded by name or specific description, existed prior to the Policy Effective Date.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on the Policy Effective Date, is in conflict with the laws of the state in which Your policy was issued, will be amended to conform to the minimum requirements of those laws.

SECTION 6: CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of a claim must be given to Us within 60 days after the start of a covered loss or as soon thereafter as reasonably possible. Notice given by or on behalf of the Policyowner or Beneficiary to Us at Our Executive Office, or to an authorized agent of the Company, with information sufficient to identify the Policyowner, will be deemed notice of claim to Us.

CLAIM FORMS: When We receive notice of a claim, We will send forms for filing Proof Of Loss. If these forms are not sent within 15 days, You will meet the Proof Of Loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proofs Of Loss section.

PROOF OF LOSS: Written Proof of Loss must be furnished to Us at Our Executive Office within 90 days after the loss for which You are seeking benefits. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within that time, provided such proof is furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

One or more of the following, together with Your written statement or Power of Attorney, may be required as Proof of Loss:

- an autopsy report;
- a Physician's statement;
- itemized bills for purchases or services rendered;
- Hospital, medical and Physician records;
- completed Company claim forms;
- adoption papers, birth, marriage, or death certificates;
- medical and pharmaceutical receipts; and
- transportation and lodging receipts.

TIME OF PAYMENT OF CLAIMS: Benefits for any loss covered under this policy will be paid immediately upon Our receipt of due written Proof of Loss.

PAYMENT OF CLAIMS: Benefits will be paid directly to the Policyowner. Any benefits unpaid at the time of the Policyowner's death will be paid in the following order: to any approved assignee, to the Beneficiary, or to the Policyowner's estate.

EXTENSION OF BENEFITS: Termination of the policy shall be without prejudice to any continuous loss which commenced while the policy was in force but the Extension of Benefits beyond the period the policy was in force may be predicated upon the payment of the maximum benefits.

ASSIGNMENT OF BENEFITS: We will not be bound by any assignment of benefits request or authorization form unless We have given Our prior consent.

UNPAID PREMIUM: When a claim is paid, any Premium due and unpaid may be deducted from the claim payment.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have You examined as often as reasonably necessary while a claim is pending. We can require an autopsy where allowed by law. Either will be done at Our expense.

LEGAL ACTION: You cannot take legal action against Us for benefits under this policy:

- within 60 days after You have sent Us written Proof of Loss; or
- more than three (3) years from the time written proof is required to be given.

LEAVE THIS AREA BLANK

Application To: FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA
Executive Office: P.O. Box 470608, Cleveland, OH 44147

[CardiaCare Plus – Series 5]

IMPORTANT: Check which person is proposed to be the Policyowner. (If no box is checked the Applicant will be the Policyowner.)

❑ Applicant's Name (Please Print: First, Middle Initial, Last)	❑ Male ❑ Female	Age	Date of Birth
❑ Husband or Wife's Name (If Family or Married Couple Coverage)	❑ Male ❑ Female	Age	Date of Birth

Applicant's Address: Number & Street City County State Zip

Applicant's Phone #	Applicant's Employer's Name
Applicant's Employee ID (If needed for billing purposes)	Husband or Wife's Employer's Name (If Family or Married Couple Coverage)
Beneficiary's Name and Address	Relationship to Proposed Policyowner

Q. Has a medical professional EVER diagnosed or treated anyone proposed to be covered under this policy for any of the following?
A Heart Murmur or Mitral Valve Prolapse is allowable as long as there is no other condition that would otherwise exclude the applicant/person.

Aneurysm	Cardiovascular Disorder	Endocarditis	Myocarditis
Angina, Angina Pectoris	Carotid Artery Disease	Enlarged Heart / Cardiomegaly	Pacemaker
Angioplasty	Cerebrovascular Disease	Hardening of the Arteries	Pericarditis
Aortic Valve Disorder	Cerebrovascular Insufficiency	Heart Attack	Pulmonary Valve Disorder
Arrhythmia, Dysrhythmia	Chronic Kidney Disease (CKD)	Heart Block, AV Block	Rheumatic Heart Disease
Atrial Thrombosis	Congestive Heart Failure	Heart Failure	Stenosis of any Artery
Arteriosclerotic Heart Disease	Coronary Artery Disease	Hemorrhage	Stent Insertion
Atherosclerosis	Coronary Bypass	Ischemic Heart Disease	Stroke, Mini-stroke
Atrial Fibrillation (A-fib)	Coronary Heart Disease	Kidney Failure	Tachycardia
Bradycardia	Coronary Occlusion	Malignant Hypertension	Thrombosis
Bundle Branch Block	Defibrillator	Marfan Syndrome	Transient Ischemic Attack (TIA)
Cardiac Arrest	Disorder of the Heart	Mitral Valve Disorder	Tricuspid Valve Disorder
Cardiomyopathy	Embolism	Myocardial Infarction (MI)	Ventricular Fibrillation (V-fib)

❑ YES ❑ NO If "YES," record name(s) of person(s)_____
The Company will not be liable for any loss under the policy for the named person(s). Under the ICU Rider (if selected), the Company will not be liable for any loss that is contributed to or results from any of the above listed conditions for the named person(s) and benefits will be limited to up to seven (7) days for confinements relating to any other reason.

Q. Has a medical professional EVER diagnosed or treated anyone proposed to be covered under this policy for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

❑ YES ❑ NO If "YES," record name(s) of person(s). _____
The Company will not be liable for any loss under the policy or any rider(s) for the named person(s).

Q. Do you give Family Heritage permission to show your name for marketing purposes? ❑ YES ❑ NO

Q. Have you ever purchased any other insurance with Family Heritage? ❑ YES ❑ NO

Q. Will this coverage replace any other accident and sickness insurance presently in force? ❑ YES ❑ NO
If "YES," please sign a Replacement form.

[*Q.* Would you like your policy delivered to you electronically? ❑ YES ❑ NO**]**

[*Q.* If "YES," please provide your e-mail address: _____ **]**

HEART COVERAGE		INTENSIVE CARE UNIT COVERAGE		PAYMENT	
LEVEL	**TYPE**	**LEVEL**	**TYPE**	**MODE**	
❑ Elite ❑ Preferred ❑ Standard	❑ Individual ❑ Single Parent ❑ Married Couple ❑ Family	❑ Elite ❑ Preferred ❑ Standard	❑ Individual ❑ Single Parent ❑ Married Couple ❑ Family	❑ A/C Monthly ❑ Semi-Annual ❑ Annual **[**❑ _____ **]**	Heart $ _____ ICU $ _____ _____ **TOTAL** $ _____
EXECUTIVE OFFICE USE				Amount Collected $	

FORM H4APP-AR

APPLICATION RECEIPT

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received from_____ the sum of $_____which has been tendered as payment of the first ❑A/C Monthly ❑Semi-Annual ❑Annual premium for the policy which has been applied for with Family Heritage Life Insurance Company of America. It is understood that, if issued, the policy will be in force as of the effective date shown in the policy. If the application is declined by the Company, no insurance will begin and the above payment will be returned to the applicant.

Date_____Licensed Company Representative _____

IF YOU DO NOT HEAR FROM THE COMPANY OR RECEIVE YOUR POLICY WITHIN 30 DAYS, CALL OR WRITE TO THE COMPANY, GIVING THE NAME OF THE PERSON WHO SIGNED THIS RECEIPT, THE TYPE OF POLICY APPLIED FOR, THE AMOUNT PAID AND THE DATE.

IMPORTANT NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICANT'S STATEMENT: I have read, or have had read to me, the completed application. The above representations are true to the best of my knowledge and belief. I understand that: any false statements or misrepresentations in this application may result in loss of coverage; the agent has no authority to approve the application, change the policy or waive any policy provisions; and, no insurance will be effective until the date stated in my policy.

Date: _____ Signature of Applicant: _____

THIS SECTION TO BE COMPLETED BY AGENT: I hereby certify that I have explained to the applicant all exceptions and limitations pertaining to the coverage(s) applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the applicant. I further certify that I am a licensed agent in the state where this application is being signed.

Date: _____ Signature of Agent: _____ Agent #: _____

Signed in the city of: _____ State of: _____

AUTHORIZATION TO HONOR DEDUCTIONS DRAWN BY FAMILY HERITAGE LIFE INSURANCE COMPANY

Draft From: ❑ Checking ❑ Savings ❑ Third Party

Account in the name of:_____
(Print Name as Shown on Bank Documents)

Name of Bank and Branch:_____

City:_____State:_____

ACH Routing #:___ ___ ___ ___ ___ ___ ___ ___ ___ Account #:_____
(always 9 digits)

I (we) hereby authorize Family Heritage Life Insurance Company of America (Family Heritage) to initiate entries to my (our) checking/savings account at the financial institution listed above (The Financial Institution), and, if necessary, initiate adjustments for any transaction credited/debited in error. The authority will remain in effect until Family Heritage is notified by me (us) in writing to cancel it in such time as to afford Family Heritage and The Financial Institution a reasonable opportunity to act on it. Such writing will be sent by me (us) to Family Heritage at the Executive Office in Cleveland, Ohio.

I request that such deductions be drawn from my account on the_____day of each month.
(Note: the 29th, 30th, and 31st are not available dates)

Date_____ Signature of Bank Depositor_____

AGENT CHECKLIST

Review Application
- ❑ Health Questions
- ❑ Signatures
- ❑ Age Matches Birth Date
- ❑ Accuracy

Did You Collect?
- ❑ Acknowledgement
- ❑ Check
- ❑ Deposit Slip (AC only)
- ❑ Additional Forms

Follow Up Actions
- ❑ Solidify Sale
- ❑ Collect Referrals
- ❑ Field Recruit
- ❑ Ask for Pre Approach

HEART POLICY CHANGE FORM **Policy #** _____

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA
P.O. BOX 470608, CLEVELAND, OH 44147

Policyowner's Name (Please Print: First, Middle Initial, Last)	❑ Male ❑ Female	Date of Birth	Age
Spouse's Name (If Family or Married Couple Coverage)	❑ Male ❑ Female	Date of Birth	Age

Policyowner's Address: Number and Street City County State Zip Phone Number ( )

Beneficiary's Name and Address Relationship to the Policyowner

SECTION 1: TYPE OF CHANGE REQUESTED (Check all that apply)

❑ Reinstatement*	❑ Coverage Level Increase*	❑ Coverage Level Decrease	❑ Add Family Member(s)*	❑ Remove Family Member(s)	❑ Remove Rider

* Medical records may be required for any person(s) covered or to be covered under this policy. The Company reserves the right to reject any coverage change or reinstatement based on existing or previous medical conditions.

SECTION 2: COVERAGE

HEART COVERAGE		INTENSIVE CARE UNIT COVERAGE		PAYMENT	
LEVEL	**TYPE**	**LEVEL**	**TYPE**	**MODE**	
❑ Elite	❑ Individual	❑ Elite	❑ Individual	❑ A/C Monthly	Heart $ _____
❑ Preferred	❑ Single Parent	❑ Preferred	❑ Single Parent	❑ Semi-Annual	ICU $ _____
❑ Standard	❑ Married Couple	❑ Standard	❑ Married Couple	❑ Annual	**TOTAL** $ _____
	❑ Family		❑ Family		

SECTION 3: ADDING FAMILY MEMBER(S) TO COVERAGE; INCREASING LEVEL OF COVERAGE; REINSTATEMENT

Q. Has a medical professional EVER diagnosed or treated anyone proposed to be covered under this policy for any of the following?
A Heart Murmur or Mitral Valve Prolapse is allowable as long as there is no other condition that would otherwise exclude the applicant/person.

Aneurysm	Cardiovascular Disorder	Endocarditis	Myocarditis
Angina, Angina Pectoris	Carotid Artery Disease	Enlarged Heart / Cardiomegaly	Pacemaker
Angioplasty	Cerebrovascular Disease	Hardening of the Arteries	Pericarditis
Aortic Valve Disorder	Cerebrovascular Insufficiency	Heart Attack	Pulmonary Valve Disorder
Arrhythmia, Dysrhythmia	Chronic Kidney Disease (CKD)	Heart Block, AV Block	Rheumatic Heart Disease
Atrial Thrombosis	Congestive Heart Failure	Heart Failure	Stenosis of any Artery
Arteriosclerotic Heart Disease	Coronary Artery Disease	Hemorrhage	Stent Insertion
Atherosclerosis	Coronary Bypass	Ischemic Heart Disease	Stroke, Mini-stroke
Atrial Fibrillation (A-fib)	Coronary Heart Disease	Kidney Failure	Tachycardia
Bradycardia	Coronary Occlusion	Malignant Hypertension	Thrombosis
Bundle Branch Block	Defibrillator	Marfan Syndrome	Transient Ischemic Attack (TIA)
Cardiac Arrest	Disorder of the Heart	Mitral Valve Disorder	Tricuspid Valve Disorder
Cardiomyopathy	Embolism	Myocardial Infarction (MI)	Ventricular Fibrillation (V-fib)

❑ YES ❑ NO If "YES," record name(s) of person(s)_____
The Company will not be liable for any loss under the policy for the named person(s). Under the ICU Rider (if selected), the Company will not be liable for any loss that is contributed to or results from any of the above listed conditions for the named person(s) and benefits will be limited to up to seven (7) days for confinements relating to any other reason.

Q. Has a medical professional EVER diagnosed or treated anyone proposed to be covered under this policy for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

❑ YES ❑ NO If "YES," record name(s) of person(s). _____
The Company will not be liable for any loss under the policy or any rider(s) for the named person(s).

Policy # _____

SECTION 4: REMOVING FAMILY MEMBER(S) FROM COVERAGE (Answer all of the following questions.)

Are you requesting the removal of a family member because of the death of the Policyowner? ❑ YES ❑ NO
If YES, please provide a death certificate.
Are you requesting the removal of a family member because of divorce from the Policyowner? ❑ YES ❑ NO
If YES, please indicate the date of divorce: _____
After removing family members from coverage, are there any dependent children who will remain under your coverage? ❑ YES ❑ NO

SECTION 5: FAMILY MEMBERS (List the name, relationship, and birthdate of all family members who will remain on this policy.)

Name	Relationship (Child, Spouse)	Date of Birth	Remove/Add

IMPORTANT NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SECTION 6: APPLICANT'S STATEMENT

I have read, or have had read to me, the completed application. The above representations are true to the best of my knowledge and belief. I understand that:

For all changes:
- Any false statements or misrepresentations in this application may result in loss of coverage;
- The agent has no authority to approve the application, change the policy, or waive any policy provisions; and,
- The Company will notify me of any adjustment in premium.

For additions and changes in coverage:
- If I am adding a family member to my coverage, the family member will not be covered until this application is approved by the Company, I have paid the appropriate premium, and the family member has satisfied the waiting period, if any;
- My existing coverage will remain in effect until the Company issues a change in coverage and a new Coverage Effective Date; and,
- If anyone to be covered under the policy is diagnosed with heart disease, heart attack, or a stroke within 30 days following the Coverage Effective Date of an increase in coverage, the increase will be voided and my coverage and premium will return to the previous levels.

For reinstatements:
- Unless the Company disapproves this application, the coverage will be reinstated either as of the date that this application is approved, or on the 45th day after the date of the conditional receipt of my premium payment; and,
- The reinstated coverage will cover loss that results from a covered disease, if any, which is first diagnosed more than 10 days after the reinstatement date and for Intensive Care Unit coverage, hospitalizations which begin after the reinstatement date.

AUTHORIZATION: I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau to furnish any information with respect to any illness or accident, medical history or medical records to Family Heritage Life Insurance Company of America (Family Heritage) or its representative to review for underwriting purposes. I understand that this authorization is voluntary and I may revoke it at any time by submitting a written revocation to Family Heritage. If I do revoke this authorization, it will not have any affect on any information released before Family Heritage's receipt of the revocation, including any action taken by the individual/entity that received the health information. I further understand that I or my authorized representative may request to see and copy the information described in this authorization and that I am entitled to a signed copy of this authorization. I acknowledge that unless an earlier date is specified under applicable law, this authorization will expire 90 days from the date signed.

Date: _____ Signature of Applicant: _____

AUTHORIZATION TO HONOR DEDUCTIONS DRAWN BY FAMILY HERITAGE LIFE INSURANCE COMPANY

Draft From: ❑ Checking ❑ Savings ❑ Third Party

Account in the name of:_____
(Print Name as Shown on Bank Documents)

Name of Bank and Branch:_____

City:_____State:_____

ACH Routing #:___ ___ ___ ___ ___ ___ ___ ___ ___ Account #:_____
(always 9 digits)

I (we) hereby authorize Family Heritage Life Insurance Company of America (Family Heritage) to initiate entries to my (our) checking/savings account at the financial institution listed above (The Financial Institution), and, if necessary, initiate adjustments for any transaction credited/debited in error. The authority will remain in effect until Family Heritage is notified by me (us) in writing to cancel it in such time as to afford Family Heritage and The Financial Institution a reasonable opportunity to act on it. Such writing will be sent by me (us) to Family Heritage at the Executive Office in Cleveland, Ohio.

I request that such deductions be drawn from my account on the_____day of each month. ***(Note: the 29th, 30th, and 31st are not available dates)***

Date_____ Signature of Bank Depositor_____

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

Executive Office: P.O. Box 470608, Cleveland, Ohio 44147

SPECIFIED DISEASE COVERAGE
Heart Disease, Heart Attack, and Stroke Policy

THIS POLICY PROVIDES LIMITED BENEFITS.
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

OUTLINE OF COVERAGE

Policy Form H4POLRAR

This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.

PLEASE READ YOUR OUTLINE OF COVERAGE CAREFULLY

This outline of coverage provides a very brief description of the important features of your coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

SPECIFIED DISEASE – HEART DISEASE, HEART ATTACK, & STROKE COVERAGE

Specified disease coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

DESCRIPTION OF BENEFITS

FIRST OCCURRENCE BENEFIT: $1,000/$2,000/$3,000 when you are diagnosed for the first time, while covered under the policy, as having had a heart attack or stroke. **This benefit is not payable for a diagnosis of heart disease.** This benefit is payable only once per covered person, regardless of the number of times the covered person is diagnosed with a heart attack or stroke. This benefit will be paid even when a heart attack or stroke is diagnosed after your death.

HOSPITALIZATION BENEFIT: $150/$300/$450 for each day you are hospitalized as an inpatient for the treatment of heart disease, heart attack, or stroke. This benefit will be calculated based on the number of days the hospital charges you for room and board. If you receive treatment in a U.S. Government Hospital, this benefit will be calculated based on the number of days you are hospitalized as an inpatient.

AMBULANCE BENEFIT: Charges up to **$200/$400/$600** per one-way trip, if a licensed surface or air ambulance service transports you to or from a hospital where you are hospitalized as an inpatient for the treatment of heart disease, heart attack, or stroke. This benefit is limited to two one-way trips per hospitalization.

PLEASE RETAIN THIS FOR YOUR RECORDS

HEART TRANSPLANT BENEFIT: $50,000/$100,000/$150,000 if, because of heart disease or heart attack, your heart can no longer adequately function and you are at risk of dying and as a result you receive a human heart transplant. This benefit will be paid no more than once for any covered person. This benefit is not payable for the replacement of a human heart with a non-human, mechanical, or artificial heart.

SURGERY AND ANESTHESIA BENEFIT: $200/$400/$600 for surgery and anesthesia. The surgery must be performed by a doctor to treat or diagnose heart disease, heart attack, or stroke.

This benefit will also pay **$200/$400/$600** for each day of hospitalization (as an inpatient) necessary to recover from surgery beginning with the day of the surgery. This payment will be made for each such day a hospital charges you for room and board, or if the surgery is performed in a hospital that does not charge for room and board, we will pay for each such day of your hospitalization as an inpatient.

This benefit is payable in addition to the Hospitalization Benefit, but only once per hospitalization. This benefit is limited to **$5,000/$10,000/$15,000** per surgery.

PHYSICAL THERAPY BENEFIT: $30/$60/$90 for each day that you receive the services of a registered physiotherapist. This benefit is payable for the same number of days for which you receive benefits under the Hospitalization Benefit, up to a maximum of 30 days per hospitalization.

HEALTHY HEART BENEFIT: $30/$60/$90 for one Cholesterol Screening for each covered person that is performed within the first 12 months following the policy effective date.

This benefit also pays up to a maximum of **$50/$100/$150** per calendar year for each covered person who has one or more of the following tests performed:

- **$50/$100/$150** for a cardiac Magnetic Resonance Imaging (MRI); and
- **$30/$60/$90** for an Electrocardiogram (EKG or ECG), Cardiac Stress Test, Echocardiogram (Echo), Cardiac X-ray, or Computed Tomography.

The above tests must be administered by a medical professional. No diagnosis of heart disease, heart attack, or stroke is required for this benefit to be payable. This benefit is not subject to the 30-day Waiting Period.

TRANSPORTATION BENEFIT: This benefit is payable if you must travel to a hospital that is more than 80 miles one-way from your residence for:

- up to three (3) appointments with a physician concerning your diagnosed heart disease, heart attack, or stroke that occur before treatment begins; or
- anytime you receive covered treatment for your diagnosed heart disease, heart attack, or stroke that is prescribed by your local physician that is not available where you live.

For your coach class airplane, train, or bus fare on a regularly scheduled commercial route to the hospital this benefit pays charges up to **$1,000/$2,000/$3,000** per round trip. For travel by automobile this benefit pays **20 cents/40 cents/60 cents** for each mile you travel. To determine the mileage, we will measure the distance from where you live to the hospital using the most direct route.

FAMILY MEMBER TRANSPORTATION BENEFIT: This benefit is payable if:

- you are eligible for the Transportation Benefit;

- a family member also travels to the hospital; and
- the hospital is more than 80 miles one-way from where the family member lives.

For the family member's coach class airplane, train, or bus fare on a regularly scheduled commercial route to the hospital, this benefit pays charges up to **$1,000/$2,000/$3,000** per round trip. For travel by automobile, this benefit pays **20 cents/40 cents/60 cents** for each mile the family member travels. To determine the mileage, we will measure the distance from where the family member lives to the hospital using the most direct route. The mileage benefit is not payable if the family member travels in the same automobile with you.

This benefit is limited to one family member making one round trip for each time the Transportation Benefit is paid. "Family member" means your spouse, parent, grandparent, grandchild, brother, sister, or child.

SECOND PARENT TRANSPORTATION BENEFIT: This benefit is payable if the Family Member Transportation Benefit is paid for a parent and a second parent also travels to the hospital under all of the following conditions:

- this is a Family Policy;
- the Transportation Benefit is payable for a covered child; and
- the hospital is more than 80 miles one-way from where the second parent lives.

For the second parent's coach class airplane, train, or bus fare on a regularly scheduled commercial route to the hospital, this benefit pays charges up to **$1,000/$2,000/$3,000** per round trip. For travel by automobile the benefit will pay **20 cents/40 cents/60 cents** for each mile the second parent travels. To determine the mileage, we will measure the distance from where the second parent lives to the hospital using the most direct route. This mileage benefit is not payable if the second parent travels in the same automobile with you. This benefit is limited to a second parent making one round trip for each time the Transportation Benefit is paid.

FAMILY MEMBER LODGING BENEFIT: Charges up to **$50/$100/$150** for a family member's lodging in a hotel or motel under the following conditions:

- You are hospitalized as an inpatient for the treatment of heart disease, heart attack, or stroke; and
- Your family member also travels to the hospital that is more than 80 miles one-way from where you and your family member live.

This benefit is limited to payment for one hotel or motel room for each day of your hospitalization, up to a maximum of 60 days for each period of hospitalization.

RETURN OF PREMIUM BENEFIT: This benefit is payable if the policy is kept in force until the return of premium maturity date. You are not required to surrender your policy on the return of premium maturity date to receive this benefit. (The return of premium maturity date is the 20th policy anniversary date or the date when we receive 20 full years of premium and provide 20 full years of coverage, whichever is later.)

The benefit amount is equal to the premiums paid while this policy was in force minus any claims incurred prior to the return of premium maturity date. Premiums paid for any rider will be included in the benefit amount only if that rider is in force on the return of premium maturity date.

For Individual or Single Parent Policies: If the policyowner dies while this policy is in force and prior to the return of premium maturity date, we will pay a benefit amount equal to the premiums paid

while this policy was in force, minus any claims incurred while this policy was in force. We will pay this benefit upon our receipt of proof of the policyowner's death.

For Family or Married Couple Policies: If the policyowner and spouse both die while this policy is in force and prior to the return of premium maturity date, we will pay a benefit amount equal to the premiums paid while this policy was in force, minus any claims incurred, while this policy was in force. We will pay this benefit upon our receipt of proof of the policyowner and spouse's death.

LIMITATIONS AND EXCLUSIONS

Except for the Healthy Heart and Return of Premium Benefits, this policy provides benefits only for loss due to heart disease, heart attack, or stroke. This includes conditions or diseases caused or aggravated by or resulting from Heart Disease, Heart Attack, or Stroke or the treatment of Heart Disease, Heart Attack, or Stroke.

This policy has a 30-day waiting period. No benefits are payable for heart disease, heart attack, or stroke diagnosed within 30 days of the policy effective date.

Benefits paid for any one person will not exceed the maximum benefits shown in the policy regardless of the number or types of heart disease, heart attack, or stroke.

A diagnosis of cardiac arrest is not, by itself, a positive diagnosis of heart disease, heart attack, or stroke.

RENEWABILITY

This policy is guaranteed renewable for life. Rates may be changed only if changed on all policies of this kind in your state.

COVERAGE

Benefit dollar amounts are stated throughout this Outline of Coverage in the following order from left to right: **Standard Level/Preferred Level/Elite Level.**

You have applied for the ☐ **Standard** ☐ **Preferred** ☐ **Elite** benefit level.

PLEASE RETAIN THIS FOR YOUR RECORDS

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

P.O. Box 470608, Cleveland, OH 44147, (440) 922-5151

HEART AND ICU CLAIM FORM

Instructions:
1. Have the claimant answer all questions, sign and date SIDE 1.
2. Have the treating physician complete SIDE 2.

If filing a **heart claim** submit one claim form for each hospital admission along with all itemized hospital bills, bills from the doctor or surgeon, and diagnostic reports showing the diagnosis of heart disease, heart attack, or stroke.

If filing an **intensive care claim** submit one claim form for each hospital admission along with a copy of the itemized hospital bill listing the intensive care charges and an ambulance bill, if applicable.

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1. Policyowner's name: _____ 2. Policy number: _____

3. Claimant's name: _____ 4. SSN: _____

5. Address: _____

6. Phone #: _____ 7. Date of birth: _____

8. Relation to Policyowner: ❑ Self ❑ Spouse ❑ Son ❑ Daughter ❑ Other _____

9. Describe illness/injury: _____

10. Date first consulted physician: _____ 11. Date diagnosed: _____

12. Has the claimant ever had this condition before? ❑ YES ❑ NO If YES, when? _____

13. List all treating physicians (Include name and phone #): _____

_____

_____

14. Name and phone # of family physician: _____

15. If Hospitalized, when? From: _____ To: _____ Hospital phone #: _____

16. Hospital name: _____
City State

17. Have you ever filed a claim for this condition with Family Heritage? ❑ YES ❑ NO

IMPORTANT NOTICE: Any person who, knowingly facilitates a fraud or has intent to defraud an insurer, or submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

AUTHORIZATION MUST BE SIGNED BEFORE A CLAIM CAN BE PROCESSED

I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau to furnish any information with respect to any illness or accident, medical history or medical records for the Patient to Family Heritage Life Insurance Company of America (Family Heritage) or its representative for the purpose of evaluating claims for benefits. I understand that this authorization is voluntary and I may revoke it at any time by submitting a written revocation to Family Heritage. If I do revoke this authorization, it will not have any affect on any information released before Family Heritage's receipt of the revocation, including any action taken by the individual/entity that received the health information. I further understand that I or my authorized representative may request to see and copy the information described in this authorization and that I am entitled to a signed copy of this authorization. I acknowledge that unless an earlier date is specified under applicable law, this authorization will expire 90 days from the date signed.

Signed _____ Date _____
Patient, Parent (If Child) or Executor

IF THE CLAIMANT IS UNABLE TO PROVIDE A SIGNATURE, PLEASE INCLUDE A COPY OF A POWER OF ATTORNEY, LETTER OF EXECUTOR AND/OR DEATH CERTIFICATE.

SUPPLEMENTAL PHYSICIAN'S STATEMENT TO BE COMPLETED BY TREATING PHYSICIAN

1. Has the patient **ever** been diagnosed with or treated for heart disease, a heart attack, or stroke? ❑ YES ❑ NO

   If YES, date of first diagnosis: _____ Date of first treatment: _____

2. List Diagnosis Code(s): A) _____ B) _____ C) _____

3. List reason for hospitalization: _____

4. Was the patient ever diagnosed with the above condition prior to this admission? ❑ YES ❑ NO

   If YES, when? _____

5. Was patient hospitalized solely due to this condition? ❑ YES ❑ NO

   If YES, name & address of facility: _____

   Date admitted: _____ Date discharged: _____

6. List any applicable surgical CPT codes: A) _____ B) _____ C) _____

7. List any other applicable procedure codes: A) _____ B) _____ C) _____

8. List any specific dates of Intensive Care Unit confinement: _____

9. Do you have records of the patient's past medical history? ❑ YES ❑ NO

10. Has the patient ever been diagnosed with AIDS/ARC? ❑ YES ❑ NO If YES, when? _____

Physician's Information:

Physician's Name: _____

Specialty: _____

Address and phone number: _____

Completed by (please print): _____ Position/Title: _____

Physician's Signature: _____ **Date:** _____

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

Home Office: P.O. Box 470608, Cleveland, OH 44147 • (440) 922-5151 • Fax (440) 922-5223

EXECUTIVE OFFICE USE: **Underwriter:** _____ **Policy Number:** _____

UNDERWRITING INFORMATION RELEASE

In the application for coverage, you were named as being treated for or diagnosed as having or had a medical condition. Please complete Section I and return it to the Home Office. We will submit the form to the physician below in order to establish if coverage can be provided. This physician must have medical information regarding the condition described.

Section I: APPLICANT'S STATEMENT

1) Name of Patient: _____

2) Name of treating Physician: _____

3) Physician's Address and Phone Number: _____

_____ ( ) -

4) Please describe the identified medical condition in detail: _____

_____

_____

5) List last known date of diagnosis or treatment regarding the above condition: _____
(month/year)

AUTHORIZATION MUST BE SIGNED BEFORE APPLICATION CAN BE PROCESSED

I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau to furnish any information with respect to any illness or accident, medical history or medical records for the Patient to Family Heritage Life Insurance Company of America (Family Heritage) or its representative to review for underwriting purposes. I understand that this authorization is voluntary and I may revoke it at any time by submitting a written revocation to Family Heritage. If I do revoke this authorization, it will not have any affect on any information released before Family Heritage's receipt of the revocation, including any action taken by the individual/entity that received the health information. I further understand that I or my authorized representative may request to see and copy the information described in this authorization and that I am entitled to a signed copy of this authorization. I acknowledge that unless an earlier date is specified under applicable law, this authorization will expire 90 days from the date signed.

Signed _____ **Date** _____
Patient (or Parent if Patient is a Child)

Section II: PHYSICIAN STATEMENT (please complete this section regarding patient named above)

1) Please describe the patient's medical condition in detail: (Attach a statement or use the back if more space is needed.)

_____

_____

2) When was the patient **first** treated or diagnosed with the described condition? _____

3) When was the patient **last** treated or diagnosed with the described condition? _____

4) Has the patient been prescribed medication AND/OR a medical device to treat the condition? ❑ YES ❑ NO

5) When was the patient first AND last seen by you? _____

6) List the name AND phone number of the referring physician: _____

Physician's Signature _____ **Date** _____

SERFF Tracking Number:	*FHLA-127619145*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*49746*
Company Tracking Number:	*H4ARPOL*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002 Dread Disease*
Product Name:	*Individual Specified Disease (Heart/Stroke) Policy*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/27/2011

Comments:

Form AR-GUAR (attached - approved by the Department on 8/6/1999 & later revised with required updates) is the form issued to all Arkansas policyholders pursuant to Rule & Regulation 49.

Form AR-LTR (attached - approved by the Department on 8/6/1999) is our Consumer Information Notice and will be issued to all Arkansas policyholders.

The Flesch Readability Certification is attached.

The Certification for Rule & Regulation 19 is attached.

Attachments:

Ar-guar.pdf

AR-LTR.pdf

Readability Certificate.pdf

Rule & Regulation 19.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/27/2011
Bypass Reason:	The application for this policy can be found under the Form Schedule tab.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Health - Actuarial Justification	Approved-Closed	09/27/2011

Comments:

Attachment:

AR Memorandum.pdf

		Item Status:	Status Date:

SERFF Tracking Number:	*FHLA-127619145*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*49746*
Company Tracking Number:	*H4ARPOL*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002 Dread Disease*
Product Name:	*Individual Specified Disease (Heart/Stroke) Policy*		
Project Name/Number:	*/*		

Bypassed - Item:	Outline of Coverage	Approved-Closed	09/27/2011
Bypass Reason:	The Outline of Coverage for this policy can be found under the Form Schedule tab.		
Comments:			

		Item Status:	**Status Date:**
Satisfied - Item:	Cover Letter	Approved-Closed	09/27/2011

Comments:

Attachment:

Cover Letter.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Sample Policy Schedule	Approved-Closed	09/27/2011

Comments:

Attachment:

Policy Schedule.pdf

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rates yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or a similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy of contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

FAMILY HERITAGE

Life Insurance Company of America

A Southwestern/Great American Company

Dear Insured,

We are here to serve you...

As our policyholder, your satisfaction is very important to us. If you have a question about your policy, if you need assistance with a problem, or if you have a claim, you should contact our Home Office at (440) 922-5222 or write to us at P.O. Box 470608, Cleveland, OH 44147. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

Should you feel you are not being treated fairly with respect to a claim, you may contact the Arkansas Department of Insurance with your complaint.

To contact the Department, write or call:

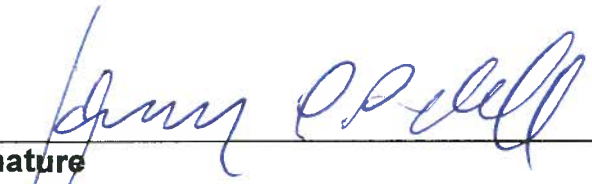
Consumer Services Division
Arkansas Insurance Department
1200 W. 3rd Street
Little Rock, AR 72201-1904
(501) 371-2640 or 1-800-852-5494

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Family Heritage Life Insurance Company of America

I hereby certify that Policy Form H4POLRAR meets the minimum reading ease score on the Flesch Reading Ease Test and that it complies with the requirements of ACA 23-80-206, cited as the Life and Accident and Health Insurance Policy Language Simplification Act.



Signature

Henry G. Grendell

Name

Vice President & General Counsel

Title

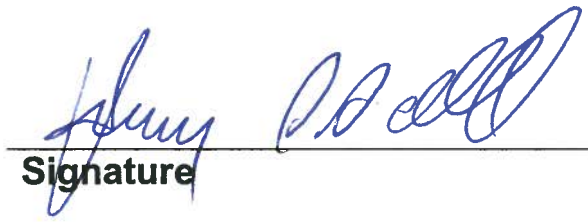
September 6, 2011

Date

FAMILY HERITAGE®
Life Insurance Company Of America

Certification of Compliance with Rule and Regulation 19

I hereby certify that this submission (Form H4POLRAR, et al) meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.



Signature

Henry G. Grendell
Name

Vice President & General Counsel
Title

September 6, 2011
Date

P.O. Box 470608 • Cleveland, Ohio 44147

(440) 922-5200 FAX: (440) 922-5201

FAMILY HERITAGE®
Life Insurance Company Of America

Submitted via SERFF

September 8, 2011

Rosalind Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201-1904

RE: Family Heritage Life Insurance Company of America NAIC # 77968
New Policy & Rate Filing – Individual Heart/Stroke Policy
Form Number: H4POLRAR, et al

Dear Ms. Minor:

Family Heritage Life Insurance Company of America would like to submit the following forms and rates for your review and approval:

Form Number	Description
H4POLRAR	Heart/Stroke Policy
H4APP-AR	Application
H4CHG-AR	Policy Change Form
H4OOCRAR	Outline of Coverage
H4CLM-AR	Claim Form
H4UIR-AR	Underwriting Information Release

The following forms were approved by the Department on 9/7/2010 and will also be used with this policy.

FORM I8RID-EAR	Intensive Care Unit Rider
FORM C8AOC-ST	Acknowledgement of Coverage

This individual heart/stroke policy will be marketed primarily on a direct basis through licensed agents. The applicant will have a choice of three benefit plans, Standard, Preferred or Elite. Benefit dollar amounts are stated throughout the policy in the following order from left to right: Standard Level/Preferred Level/Elite Level. The policy issued will include only the benefit amounts for the selected plan.

The question on the application regarding policy issue via the internet is variable and may or may not appear on the application that is eventually printed.

(440) 922-5200 FAX: (440) 922-5223

P.O. Box 470608 • Cleveland, Ohio 44147

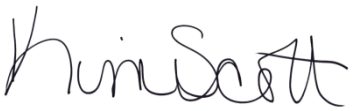
Included in this filing are the following:

- This cover letter;
- Each of the referenced forms;
- An actuarial memorandum and premium rates for the policy;
- A Flesch Certification;
- A Certification of Compliance with Rule & Regulation 19; and
- Copies of previously approved forms we issue to satisfy Rule & Regulation 49 and the Consumer Information Notice requirement.

The filing fee is being submitted via EFT.

If you have any questions or require any additional information, please contact me at (440) 922-5156 or via e-mail at kim.scott@familyheritagelife.com. Thank you for your assistance with this filing.

Sincerely,



Kim Scott
Compliance Analyst

FAMILY HERITAGE®
Life Insurance Company Of America

POLICY SCHEDULE

Policyowner:

John Doe
123 Main Street
Apartment # 109
Anytown, Anystate 12345

Agent:

Joseph Smith

Policy Number: 123456-7

Policyowner's Spouse: Jane Doe
Policy Effective Date: October 1, 2011
Payment Mode Selected: Monthly

Coverage Effective Date	Coverage Description		Monthly Premium	Semi-Annual Premium	Annual Premium
10/01/2011	CardiaCare Plus Series 5- Family - Preferred		$50.00	$300.00	$600.00
		Total	$50.00	$300.00	$600.00

You have chosen the **Automatic Payment Option.** Your monthly deductions will begin on 10/15/2011.

IMPORTANT: EXCLUSION INFORMATION
If you have answered any of the health questions on the application "YES", your coverage may include certain exclusions. A copy of your application is included with the enclosed policy for your review.

Executive Office Use:

C4WEL-OH H4POLRST H4CLM-ST P1PRI